SPEC-F FORM (ENDOCRINOLOGIST CERTIFICATION)

MISSOURI DEPARTMENT OF TRANSPORTATION
MOTOR CARRIER SERVICES

CERTIFICATION BY ENDOCRINOLOGIST FOR SKILL PERFORMANCE EVALUATION (SPE) CERTIFICATE TO OPERATE INTRASTATE COMMERCIAL MOTOR VEHICLES

MAIL COMPLETED FORM TO:	ATTN: MEDICAL EXEMPTION PROGRAM MOTOR CARRIER SERVICES P.O. BOX 893 JEFFERSON CITY, MO 65102-0893	IF ASSISTANCE NEEDED, CALL: 573-522-9001 OR Toll Free at 1-866-831-6277 FAX 573-751-4354

SECTION 1. IDENTIFICATION OF DRIVER-APPLICANT (To be completed by driver applicant.)

DRIVER-APPLICANT'S FULL NAME			MAIDEN/FORMER NAME(S)
RESIDENCE ADDRESS			GENDER (PLEASE CHECK ONE BOX) ☐ MALE ☐ FEMALE
CITY	STATE	ZIP	DATE OF BIRTH
(AREA CODE) HOME TELEPHONE # ( )	(AREA CODE) WORK PHONE # (IF ANY) ( )		SOCIAL SECURITY #

SECTION 2. IDENTIFICATION OF ENDOCRINOLOGIST (To be completed by board-certified or board-eligible Endocrinologist.)

ENDOCRINOLOGIST'S BUSINESS NAME			BOARD CERTIFIED ☐ YES ☐ NO
ENDOCRINOLOGIST'S FULL NAME			BOARD ELIGIBLE ☐ YES ☐ NO
BUSINESS ADDRESS			
CITY	STATE	ZIP	
(AREA CODE) OFFICE TELEPHONE # ( )	(AREA CODE) OFFICE FAX # ( )		PROFESSIONAL CERTIFICATION #
NAME OF CERTIFYING ORGANIZATION			PROFESSIONAL LICENSE #
ADDRESS OF CERTIFYING ORGANIZATION			
CITY	STATE	ZIP	

SECTION 3. MEDICAL HISTORY (To be completed by board-certified or board-eligible Endocrinologist.)

THE COMPLETE MEDICAL EXAMINATION MUST CONSIST OF A COMPREHENSIVE EVALUATION OF THE APPLICANT'S MEDICAL HISTORY AND CURRENT STATUS WITH A REPORT INCLUDING THE FOLLOWING INFORMATION:

DATE INSULIN USE BEGAN	INSULIN TYPE AND DOSAGES	DIABETES TYPE (PLEASE CHECK ONE BOX) ☐ TYPE 1 ☐ TYPE 2

A	WHAT IS THE APPLICANT'S CURRENT MEASURE OF GYLCOSYLATED HEMOGLOBIN (HGA1C)?	MEASUREMENT		
B	WHAT DATE WAS THE CURRENT MEASUREMENT TAKEN?	DATE OF MEASUREMENT		
C	WHAT DATE DID THE APPLICANT BEGIN USING INSULIN TO CONTROL HIS/HER DIABETES?	MONTH	DAY	YEAR
D	HOW LONG HAS THE APPLICANT BEEN USING INSULIN TO CONTROL HIS/HER DIABETES AND DRIVING A COMMERCIAL MOTOR VEHICLE?	MONTHS	DAYS	YEARS
E	HAS THE ENDOCRINOLOGIST PRESCRIBED A DIET TO BE UTILIZED FOR CONTROL OF THE APPLICANT'S DIABETES? ☐ YES ☐ NO EXPLAIN:			

NOTE: IF MORE SPACE IS NEEDED FOR YOUR RESPONSE(S) THAN THE FORM PROVIDES, PLEASE ATTACH ADDITIONAL SHEETS.

SECTION 3. MEDICAL HISTORY (To be completed by board-certified or board-eligible Endocrinologist.) (*Continued)*

F	LIST THE DATE(S) OF EACH AND EVERY HYPOGLYCEMIC REACTION OF THE APPLICANT WITHIN THE PAST FIVE YEARS, THAT EITHER:
1. RESULTED IN THE APPLICANT'S LOSS OF CONSCIOUSNESS OR SEIZURE;	
2. REQUIRED THE APPLICANT TO OBTAIN THE ASSISTANCE OF ANOTHER PERSON;	
3. RESULTED IN IMPAIRED COGNITIVE FUNCTION THAT OCCURRED WITHOUT WARNING SYMPTOMS.	
G	LIST ANY AND ALL SIGNIFICANT FACTORS: SMOKING, ALCOHOL USE, OTHER MEDICATIONS OR DRUGS TAKEN.
H	HAS THE ENDOCRINOLOGIST PERFORMED EXAMINATIONS ON THE APPLICANT TO DETECT ANY PERIPHERAL NEUROPATHY OR CIRCULATORY INSUFFICIENCY OF THE EXTREMITIES? ☐ YES ☐ NO EXPLAIN:
I	DOES THE ENDOCRINOLOGIST HAVE REPORTS OF ANY HYPOGLYCEMIC INSULIN REACTIONS WITHIN THE LAST FIVE YEARS? ☐ YES ☐ NO EXPLAIN:

CHECK EACH OF THE FOLLOWING BOXES TO CONFIRM COMPLETION

☐	A DIABETES DIAGNOSIS AND DISEASE HISTORY ←CHECK BOX TO CONFIRM COMPLETION	☐	HOSPITALIZATION RECORDS ←CHECK BOX TO CONFIRM COMPLETION
☐	CONSULTATION NOTES FOR DIAGNOSTIC EXAMINATIONS ←CHECK BOX TO CONFIRM COMPLETION	☐	FOLLOW UP REPORTS ←CHECK BOX TO CONFIRM COMPLETION
☐	SPECIAL STUDIES PERTAINING TO THE DIABETES ←CHECK BOX TO CONFIRM COMPLETION		

SECTION 4. EXAMINING ENDOCRINOLOGIST

A	IS THE ENDOCRINOLOGIST FAMILIAR WITH THE APPLICANT'S MEDICAL HISTORY FOR THE PAST FIVE YEARS THROUGH ACTUAL TREATMENT OVER THAT TIME?		
☐ YES - HOW LONG?		☐ NO	EXPLAIN:

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SECTION 4. EXAMINING ENDOCRINOLOGIST *(Continued)*

B	IS THE ENDOCRINOLOGIST FAMILIAR WITH THE APPLICANT'S MEDICAL HISTORY FOR THE PAST FIVE YEARS THROUGH CONSULTATION WITH A PHYSICIAN WHO HAS TREATED THE APPLICANT DURING THAT TIME?				
☐ YES	PHYSICIAN'S NAME	BUSINESS ADDRESS			
CITY		STATE	ZIP	(AREA CODE) BUSINESS TELEPHONE # ( )	
☐ NO - EXPLAIN:					
C	IN YOUR PROFESSIONAL OPINION, HAS THE APPLICANT BEEN EDUCATED IN DIABETES AND ITS MANAGEMENT, THOROUGHLY INFORMED OF AND UNDERSTANDS THE PROCEDURES WHICH MUST BE FOLLOWED TO MONITOR AND MANAGE HIS/HER DIABETES AND WHAT PROCEDURES SHOULD BE FOLLOWED IF COMPLICATIONS ARISE? ☐ YES ☐ NO EXPLAIN:				
D	IN YOUR PROFESSIONAL OPINION, DOES THE APPLICANT HAVE THE ABILITY AND HAS HE/SHE DEMONSTRATED WILLINGNESS TO PROPERLY MONITOR AND MANAGE HIS/HER DIABETES? ☐ YES ☐ NO EXPLAIN:				

SECTION 5. ENDOCRINOLOGIST CERTIFICATION AND VERIFICATION.

I CERTIFY THAT, IN MY MEDICAL OPINION, THE APPLICANT'S DIABETES DEFICIENCY IS STABLE AND HE/SHE IS CAPABLE OF PERFORMING THE DRIVING TASKS REQUIRED TO OPERATE A COMMERCIAL MOTOR VEHICLE, AND THAT THE APPLICANT'S CONDITION WILL NOT ADVERSELY AFFECT HIS/HER ABILITY TO OPERATE A COMMERCIAL MOTOR VEHICLE SAFELY. ☐ YES ☐ NO

I FURTHER DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF MISSOURI AND THE UNITED STATES OF AMERICA THAT ALL THE INFORMATION STATED IN THIS APPLICATION AND ALL ATTACHED INFORMATION ARE TRUE AND CORRECT.

ENDOCRINOLOGIST'S NAME (Printed)	
ENDOCRINOLOGIST'S SIGNATURE	DATE SIGNED:

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